HIPAA Assessment Guidelines

General Assessment Considerations

Our objective of the initial assessment process is to identify all program areas and systems that are potentially impacted by the changes that will occur, as the health care industry becomes HIPAA compliant. The initial assessments will be the high-level information gathering activity and the findings will facilitate the DHS to prepare a work plan to address in more detail, the many areas affected by HIPAA.

HIPAA standards will apply to the transactions, codes, and identifiers identified below. HIPAA will also required that certain security and privacy policies and procedures be established and implemented to ensure protection of health care data. HIPAA requires that the standards be used during the electronic transmission of these transactions, but these are not the only areas in our systems that are impacted. It is important to consider that there are some systems that will need to become compliant and use the X12 standards directly, and there are some systems that are indirectly impacted due to the fact that they receive data from a system that had to become compliant. Data content may need to change to meet the rules in the HIPAA Implementation Guides and it is important to consider subsystems that are downstream (or that use mutations) from the data that originates in those systems that will need to change to use standard transactions.

Within the DHS, numerous subsystems use data that originates in CA-MMIS, CD-MMIS, and MEDS. These systems will each have some changes required to meet the requirements of HIPAA. Therefore, systems that use input data that originates in CA-MMIS, CD-MMIS, or MEDS should be carefully considered for potential impact.

Below are descriptions of the business functions that will require the use of HIPAA standards followed by a brief assessment consideration description.

1. Health Care Claim: Institutional, Professional & Dental (837)

This transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. This transaction set is also used in the business function of coordination of benefits.

For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, and pharmacies, and entities providing medical information to meet regulatory requirements. The payer refers to a third party entity that pays claims or administers the insurance product or benefit or both. For example, a payer may be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), etc.) or an entity such as a third party administrator (TPA) or third party organization (TPO) that may be contracted by one of those groups. A regulatory agency is an entity responsible, by law or rule, for administering and monitoring a statutory benefits program or a specific health care/insurance industry segment.

Initial Assessment Considerations: Identify a subsystem, (interface, or file) as 'potentially impacted' if the input/output is a claim or a mutation of a claim from another system. Identify input/outputs as either hardcopy or electronic; and identify the transaction as being conducted internally (within DHS) or externally. Document any special considerations (are there open change orders for the system…or enhancements planned…new trading partners on the horizon…)

2. Health Care Claim Payment/Advice Transaction Set (835)

This transaction may be used by a health plan to make a payment to a financial institution for a health care provider (sending payment only), to send an explanation of benefits or a remittance advice directly

to a health care provider (sending data only), or to make payment and send an explanation of benefits remittance advice to a health care provider via a financial institution (sending both payment and data).

Initial Assessment Considerations: Identify a subsystem, (interface, or file) as 'potentially impacted' if there is output that is a payment or remittance transaction. Identify outputs as either hardcopy or electronic; and identify the transaction as being conducted internally (within DHS) or externally. Even if the transaction is on paper we are still capturing it just in case an enhancement to electronic comes along over the next few years…

3. Health Care Eligibility Benefit Inquiry Transaction Set (270)

This transaction set can be used to inquire about the eligibility, coverage or benefits associated with a benefit plan, employer, plan sponsor, subscriber or a dependent under the subscriber's policy. The transaction set is intended to be used by all lines of insurance such as Health, Life, and Property and Casualty.

Health Care Eligibility Benefit Response Transaction Set (271)

This transaction set can be used to communicate information about or changes to eligibility, coverage or benefits from information sources (such as - insurers, sponsors, payers) to information receivers (such as - physicians, hospitals, repair facilities, third party administrators, governmental agencies). This information includes but is not limited to: benefit status, explanation of benefits, coverage, dependent coverage level, effective dates, amounts for co-insurance, co-pays, deductibles, exclusions and limitations.

Initial Assessment Considerations: Identify a subsystem, (interface, or file) as 'potentially impacted' if there is input / output transactions that have eligibility data either directly as an inquiry/response or as a mutation of eligibility data (just in case an data content from internal code sets) changes. Again identify outputs as either hardcopy or electronic; and identify the transaction as being conducted internally (within DHS) or externally. Also provide special notes that describe any special considerations that may impact data usage.

4. Health Care Services Review – Request for Review and Response (278)

This transaction set can be used to transmit health care service information, such as subscriber, patient, demographic, diagnosis or treatment data for the purpose of request for review, certification, notification or reporting the outcome of a health care services review. Expected users of this transaction set are payers, plan sponsors, providers, utilization management and other entities involved in health care services review. This will include the TARs.

Initial Assessment Considerations: Identify a subsystem, (interface, or file) as 'potentially impacted' if the data is a service authorization request, review, or response or a mutation of any of these from another system. Identify input/outputs as either hardcopy or electronic; and identify the transaction as being conducted internally (within DHS) or externally. Document any special considerations (are there open change orders for the system…or enhancements planned…new trading partners on the horizon…)

5. Health Care Claim Status Request (276)

This transaction set can be used to transmit requests for status of specific health care claim(s). Status information may be requested at the claim or claim detail level. Expected users of this transaction set include hospitals, nursing homes, laboratories, physicians, dentists, allied professional groups, employers, and supplemental health care claims adjudication processors.

Health Care Claim Status Response (277)

This transaction set can be used to transmit responses to the 276 requests. Expected users of this transaction set would be payers and would include insurance companies, third party administrators, service corporations, state and federal agencies and their contractors, plan purchasers, and any other entity that processes health care claims.

Initial Assessment Considerations: Identify a subsystem, (interface, or file) as 'potentially impacted' if the subsystem supports this business transaction. Identify input/outputs as either hardcopy or electronic; and identify the transaction as being conducted internally (within DHS) or externally. Document any special considerations (are there open change orders for the system…or enhancements planned…new trading partners on the horizon…)

6. Benefit Enrollment and Maintenance (834)

This transaction set can be used to transmit member data. This transaction would be used by sponsors, payer/insurers, third party administrators. A sponsor may be an employer, union, government agency, association, or insurance agency.

Initial Assessment Considerations: Identify a subsystem, (interface, or file) as 'potentially impacted' if the subsystem supports this business transaction. Identify input/outputs as either hardcopy or electronic; and identify the transaction as being conducted internally (within DHS) or externally. Document any special considerations (are there open change orders for the system…or enhancements planned…new trading partners on the horizon…)

7. Health Plan Premium Payment (820)

This transaction set can be used in two specific business functions: 1) an EFT with remittance information carried through the banking system or 2) separate EFT (or paper check) and premium remittance, in which case the remittance is outside the banking network.

Initial Assessment Considerations: Identify a subsystem, (interface, or file) as 'potentially impacted' if the subsystem supports premium payments. Identify input/outputs as either hardcopy or electronic; and identify the transaction as being conducted internally (within DHS) or externally. Document any special considerations (are there open change orders for the system…or enhancements planned…new trading partners on the horizon…)

8. Code Sets

The standard codes sets are Diagnosis Code (ICD-9-CM Vol 1 & 2), Procedures Codes (CPT4, HCPCS, CDT, ICD-9-Vol 3) and Drug Codes (NDC). No State specific local codes are currently available for use in the HIPAA standards.

Initial Assessment Considerations: Identify a subsystem, (interface, or file) as 'potentially impacted' if the subsystem uses any non-standard versions of these data elements, regardless of where it originates. Identify the exchange point if it originates elsewhere.

9. Provider Identifiers

This data element will be required when used on the above listed transactions.

Initial Assessment Considerations: Identify a subsystem, (interface, or file) as 'potentially impacted' if the subsystem uses this data element regardless of where it originates. Identify the exchange point if it originates elsewhere.

10. Employer Identifiers

This data element will be required when used on the above listed transactions.

Initial Assessment Considerations: Identify a subsystem, (interface, or file) as 'potentially impacted' if the subsystem uses this data element regardless of where it originates. Identify the exchange point if it originates elsewhere.

11. Health Plan Identifiers

This data element will be required when used on the above listed transactions.

Initial Assessment Considerations: Identify a subsystem, (interface, or file) as 'potentially impacted' if the subsystem uses this data element regardless of where it originates. Identify the exchange point if it originates elsewhere.

12. Security / Privacy – Individually Identifiable Health Care Information

Individually identifiable health care information must be protected under the HIPAA rules for security and privacy. It should be noted that the ability to associate protected data with an individual must also be protected.

Initial Assessment Considerations: A broad look at the use of health care information should be evaluated and identified. During the assessment we want to capture whether or not there is health care information within a subsystem, whether or not we share any health information with others (either internally or externally) and also we want to then capture if is considered individually identifiable. During the initial assessments we are considering all health care information to be at a minimum subject to the security rules; and any individually identifiable data as subject to both the security and the privacy rules. This approach will help ensure that any eligibility or participant files that could be linked to a health information data file is identified for risk assessments that will follow. The risk assessments that will follow will then evaluated the medium and current security measures in place to evaluate the level vulnerabilities.